DEPARTMENT OF DEFENSE
NONAPPROPRIATED FUND HEALTH BENEFITS PROGRAM

Summary of Benefits

Traditional Choice® Indemnity Plan

Effective 1 January 2003

Plan Provisions	Traditional Choice Indemnity Benefits Plan Benefits*
Calendar Year Deductible	
★ Individual	$200
★ Family	$600
Out-of-Pocket Limit (the maximum amount you pay for your share of covered expenses in a calendar year. Copays, expenses covered at 50% and non-covered expenses do not count toward your Out-of-Pocket Limit)	
★ Individual	$2,000
★ Family	$6,000
Lifetime Maximum	Unlimited
Hospital Precertification Please see your Summary Plan Description (SPD) for details.	You must precertify any scheduled hospital stay. $500 penalty for failure to precertify (penalty waived if you are overseas)
Preventive Care	
★ Routine physical exam and immunizations (one per calendar year)	100%, no deductible
★ Well-child care and immunizations Birth to age 7. Please see your SPD for age and frequency schedule.	100%, no deductible
★ Routine gynecological exam including Pap test and related lab fees (one per calendar year)	100%, no deductible
★ Routine Mammogram (one per calendar year for women age 35 and over)	100%, no deductible
★ Prostate screening exam (one per calendar year for men age 40 and over)	100%, no deductible
★ Routine eye exam (one per calendar year)	80%, no deductible
★ Prescription eyewear - lenses, frames and contacts (in addition to Vision One® Discount Program)	100% up to a $75 maximum benefit per calendar year per person
★ Routine hearing exam (one per calendar year)	100%, no deductible
★ Hearing aids ($500 lifetime maximum)	100%, no deductible
Physician Services	
★ Office visits for treatment of illness or injury	80% after deductible
★ Diagnostic lab and X-ray	80% after deductible
★ Maternity care office visits	80% after deductible
★ In-office surgery	100% of first $1,000, no deductible; then 80% after deductible
★ Physician hospital visits	80% after deductible
★ Anesthesia	80% after deductible
★ Allergy testing, serum and injections	80% after deductible
★ Specialists (office visits)	80% after deductible
★ Second surgical opinion	100%, no deductible
Hospital Services	
★ Inpatient hospital room and board and ancillary services	80% after deductible
★ Inpatient and outpatient surgery	80% after deductible
★ Outpatient services	80% after deductible
★ Preoperative testing	80%, no deductible
★ Other hospital services	80% after deductible
Emergency Care	
★ Hospital emergency room	80% after deductible
★ Hospital emergency room for non-emergency care	50% after deductible
★ Ambulance	80% after deductible

** Coverage is subject to reasonable and customary charges.*

Summary of Benefits

Effective 1 January 2003

continued

Traditional Choice Indemnity Benefits

Plan Provisions	Plan Benefits*
Other Health Care	
★ Convalescent facility (up to 90 days per calendar year)	80% after deductible
★ Home health care (up to 90 visits per calendar year)	80% after deductible
★ Private duty nursing (up to 70 eight-hour shifts per calendar year)	80% after deductible
★ Hospice (inpatient and outpatient)	100%, no deductible
★ Independent lab and X-ray facilities	80% after deductible
★ Short-term rehabilitation (60-day maximum per course of treatment)	80% after deductible
★ Durable medical equipment	80% after deductible
★ Spinal disorder (chiropractic) (20 visits per calendar year)	80% after deductible
Mental Health Care**	
★ Inpatient	80% after deductible; up to 60 days per calendar year; 50% thereafter
★ Outpatient (up to 45 visits per calendar year)	80% after deductible
** *Outpatient day maximums for mental health and substance abuse are not combined.*	
Substance Abuse Treatment**	
★ Inpatient (up to 45 days per calendar year)	80% after deductible
★ Outpatient (up to 45 visits per calendar year)	80% after deductible
** *Outpatient day maximums for mental health and substance abuse are not combined.*	

Prescription Drug Benefits		
Participating Pharmacy Program (30-day supply)	*Participating Pharmacies*	*Non-Participating Pharmacies*
★ Generic drugs	100% after $10 copay	Not covered
★ Formulary brand-name drugs	100% after $20 copay	Not covered
★ Non-formulary brand-name drugs	100% after $30 copay	Not covered
Prescriptions Purchased Overseas		
★ Generic drugs	Not applicable	100% after deductible
★ Brand-name drugs	Not applicable	80% after deductible
Mail-Order Service (90-day supply)		
★ Generic drugs	100% after $10 copay	
★ Formulary brand-name drugs	100% after $20 copay	
★ Non-formulary brand-name drugs	100% after $30 copay	

** Coverage is subject to reasonable and customary charges.*

This chart displays only a general description of your benefits under the DOD NAF HBP. Should there be a conflict between the benefits shown on the chart and those in the Summary Plan Description (SPD), the terms of the SPD will be used to determine coverages and benefits.

DoD TC 02-0210 09/02